Wraparound Milwaukee

REACH Program

Plan of Care Signature Sheet

Youth Name: _____

Date of Birth: _____ **POC Date:** _____

REQUIRED TEAM MEMBER SIGNATURES

		In Attendance
Youth	Phone	☐ Yes ☐ No
Parent/Legal Guardian	Phone	☐ Yes ☐ No
Parent/Legal Guardian	Phone	☐ Yes ☐ No
Care Coordinator	Phone	☐ Yes ☐ No
Supervisor	Phone	☐ Yes ☐ No
Consulting Psychologist	Phone	☐ Yes ☐ No
Prescribing Physician	Phone	☐ Yes ☐ No

✓Client Rights Reminder

Youth /parent/legal guardian:

By signing this form you do not give up your right to grieve or appeal what is written in this Plan or the services you are receiving.

SIGNATURES OF ADDITIONAL TEAM MEMBERS

Team Member	Relationship To Youth	Phone
Team Member	Relationship To Youth	Phone
Team Member	Relationship To Youth	Phone
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Youth Name: _____

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